Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009

Recommendations for Action: Cessation Program Component

May 2005

Missouri Department of Health and Senior Services

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010

Julia M. Eckstein
Director

Matt Blunt
Governor

Dear Colleague:

Tobacco use is the leading cause of preventable death in Missouri. Unfortunately, almost 10,000 Missourians die from smoking-related illnesses each year. Approximately 1 million Missouri adults currently smoke, of which almost half tried to quit in the past year. Two-thirds report they would like to quit. This document offers hope for help to those who want to quit.

The actions recommended in this document address interventions that have been shown to increase quitting. Interventions that work include health care providers counseling patients to quit and recommending effective cessation aids with coverage for both provided in health plans. Implementation of free telephone quitline services is recommended to increase access to effective cessation counseling for all Missourians. These actions further delineate those recommended in *Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009.* The plan is available online: www.dhss.mo.gov/SmokingAndTobacco.

Medical costs to treat smoking-related illnesses in Missouri amounted to $1.67 billion in 1998, with $415 million spent to treat ill Medicaid recipients. According to studies cited by the Centers for Disease Control and Prevention (CDC), the cost savings from reducing tobacco use by providing effective cessation interventions more than pay for themselves in three to four years. The CDC recommends that Missouri spend $6.3 to $30 million annually for cessation programs.

The recommendations by the Missouri State Cessation Workgroup put forth in this document reflect the current science of how to reduce tobacco dependence. Through effective partnerships, shared responsibility for implementation of the recommendations will be established that will result in less tobacco use among Missourians.

Sincerely,

Julia M Eckstein

Julia M. Eckstein, Director
Missouri Department of Health & Senior Services

Missouri Comprehensive Tobacco Use Prevention Program
Strategic Plan 2003-2009
Recommendations for Action:

Cessation Program Component
May 2005

Division of Community Health (DCH)
Section of Chronic Disease Prevention and Health Promotion (CDPHP)

Health Promotion Unit (HPU)

Missouri Tobacco Use Prevention Program
1-866-726-9926 (toll-free)
www.dhss.mo.gov/SmokingAndTobacco

Julia M. Eckstein, Director, DHSS

Paula F. Nickelson, Director, DCH

Deborah Markenson, M.S., R.D., Administrator, CDPHP

Sherri G. Homan, R.N., Ph.D., Administrator,
Office of Surveillance, Evaluation, Planning & Health Information

Janet S. Wilson, M.P.A., M.Ed., Chief, HPU

This document was supported by Grant/Cooperative Agreement Number 99038 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

ACKNOWLEDGEMENT

Appreciation is extended to the following members of the **Missouri State Cessation Workgroup** for the time and expertise given to the development of the *Cessation Program Component Plan*. The recommendations for actions in the plan are the consensus opinion of the individuals and the organizations represented. If implemented, the actions would help thousands of Missourians to quit smoking, thereby reducing their risk of death from tobacco-related illness. This would save Missouri taxpayers millions of dollars annually to treat illnesses caused by tobacco use.

Dorothy Andrae, MHA, BSRN, CPHQ,
Regional Manager, Primaris

Barry Freedman, Vice-President of Community Initiatives,
American Lung Association of Missouri

Amy E. Gaier, Program Director,
Cancer Information Services, National Cancer Institute

Jay Goodman, Senior Vice President,
American Cancer Society, Heartland Division

Lynn Hebenheimer, Program Manager,
Division of Medical Services, Missouri Department of Social Services

Thomas L. Holloway, Director of Governmental Relations,
Missouri State Medical Association

Bonnie Linhardt, Public Advocacy Director,
Missouri American Heart Association, Heartland Affiliate

Jerry N. Middleton, MD,
American College of Obstetricians and Gynecologists, Missouri Section

Pat Plumley, MSW,
Director of Program Services, Missouri March of Dimes

Missouri Comprehensive Tobacco Use Prevention Program
Strategic Plan 2003-2009

Recommendations for Action:
Cessation Program Component

Table of Contents

May 2005

Why effective cessation services are needed in Missouri

Why effective cessation services are needed in Missouri

Tobacco use costs lives and money. Almost 10,000 (9,941) Missourians died from tobacco-related illnesses in 2000. Additionally, $1.67 billion were spent in Missouri in 1998 to treat smoking-related illnesses, including $415 million to treat ill Medicaid recipients.

Tobacco use in Missouri is a significant problem. At 27.2 percent, cigarette smoking among Missouri adults ranked third among all states in 2003. Smoking among pregnant women was 18.2 percent in 2002, ranking Missouri eighth highest in the United States. Among high school students in 2003, 24.8 percent smoked and 29.7 percent used some form of tobacco, both of which are higher than the national average.

It is estimated that smoking prevalence among Medicaid clients is 50 percent higher than general population. Smoking among poorly educated adults is significantly higher than for other adults. Among Missouri adults that have less than a high school education, 38.1 percent smoke compared to15.4 percent of those with a college education.

The estimated number of adult smokers in Missouri is 1.13 million. Many of these current smokers try to quit annually, and many more want to quit. Almost half (49.5 percent) of Missouri adult smokers reported in 2003 that they had stopped smoking for one day or longer because they wanted to quit, and 61.6 percent were seriously considering stopping smoking within the next six months. Of high school students that smoked in 2003, 60.6 percent had tried to quit in the 12 months prior to the survey, and 56.4 percent indicated they wanted to quit.

Over 60 percent (63.7) of adult tobacco users in Missouri reported they were advised in the past 12 months by a health care professional to quit. About a third (35.5 percent) had been recommended nicotine replacement drugs to help them quit and 14.7 percent were recommended to use a cessation class, counseling or quitline for help in quitting. However, too few used any form of effective cessation assistance – only 14.3 percent reported using nicotine-replacement therapies and 2.8 percent participated in cessation counseling of any kind the last quit attempt. Additionally, only 21.3 percent of current adult smokers had employers offer assistance for quitting, such as a stop smoking program.

Affordable and accessible effective cessation services are needed in Missouri to provide the million adults that smoke with the help needed to quit.

Effective cessation interventions exist

Considerable evidence exists for how to effectively treat tobacco dependence to produce long-term and permanent abstinence. Based on the results of an extensive review of available studies, the Task Force on Community Preventive Services (Hopkins, et. al 2001) recommended the following cessation interventions as having strong or sufficient evidence of effectiveness:

- **Increasing the price of tobacco products**. A 10 percent increase in the price of tobacco products will result in a 4.1 percent decrease in the amount of tobacco used by the general population.
- **Mass media education campaigns when combined with other interventions.** Brief recurring messages developed through formative research and broadcast on television and radio over long periods of time and combined with other interventions 1) decreased initiation of tobacco use by 8 percent among those exposed to the campaign compared to those not exposed to the messages, 2) reduced consumption of tobacco products by 15 packs per capita, and 3) increased cessation among tobacco users.
- **Health care provider reminder systems.** Using reminders such as chart stickers to prompt providers to identify patients who use tobacco and counsel them to quit resulted in a 32.5 percent increase in the number of patients identified as tobacco users.

- **Health care provider education and reminder systems to counsel patients** combined increased the percentage of patients receiving advice from a provider by 20 percent, and resulted in a 4.7 percent increase in number of patients who quit. Adding patient education (self-help materials) increased the number that quit by 5.7 percent.
- **Reducing out-of-pocket costs for effective treatments for tobacco use and dependence.** Reducing costs for effective cessation pharmacotherapies increased 1) use of therapies; 2) number of people attempting to quit; and 3) number of people who quit successfully. Reducing out-of-pocket costs for pharmacotherapies increased quit rates by approximately 8 percent.
- **Patient telephone support (quitlines) when combined with other interventions.** Tobacco users who received telephone counseling experienced a 41 percent improved quit rate over those who did not receive telephone counseling. Compared to self-help interventions, proactive quitlines produced a 56 percent increase in quit rates (Stead et al. 2004)

Multiple interventions produce better results

According the *Clinical Practice Guideline: Treating Tobacco Use and Dependence* (Fiore 2000), tobacco dependence is a chronic condition that often requires multiple interventions. While only approximately 5 percent of smokers that attempt to quit maintain abstinence for at least three months (CDC 2002), an increase in either quit attempts or in the success rate of attempts can lead to an overall increased cessation rate (Burns 2000).

Burns (2000) suggested that the best results in increasing quitting occur when multiple evidence-based intervention strategies are implemented producing a synergistic effect. For example, a mass media campaign to educate and motivate smokers about tobacco use and quitting also promotes the availability of telephone quitline services. Anderson and Zhu (CDC 2004) found that a secondhand smoke education media campaign in California that included a tag line for the state telephone quitline generated more calls to the quitline than ads that focused only on the health effects of smoking. Additionally, workplaces and public places that prohibit smoking are effective in not only reducing exposure to secondhand smoke, but also result in a reducing tobacco consumption overall because there are fewer places people can smoke. (Hopkins, et. al 2001) Employers that implement smoke-free policies and also offer health plan coverage for cessation counseling and pharmacotherapy can contribute significantly to the success of employees quitting.

Combining health care provider interventions with other interventions resulted in increased quitline participation and quit rates in two states. Fax referral systems implemented in Oregon and Arizona enable physicians, with patients' permission, to fax information to the state quitline, which then calls the patient to provide proactive counseling services. In Oregon, providers were offered $10 reimbursement for each fax referral resulting in 17 percent of referral patients quitting compared to 5 percent of typical quitline callers (Tobacco-free Oregon 2002).

Offering pharmacotherapies to smokers who agree to multiple telephone cessation counseling sessions increases participation significantly. In Minnesota, free nicotine patches were offered to any caller that enrolled in a four-call counseling program. This resulted in over 8,000 calls in two-months and almost 60 percent choosing the four-call program compared to only 10 to 15 percent who chose the program prior to the availability of free nicotine replacement therapy (Pacific 2003).

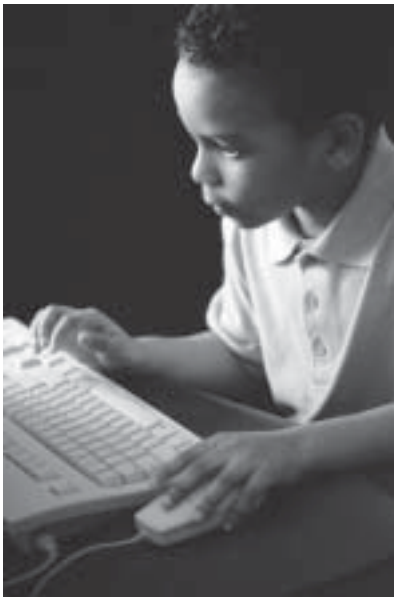
The payoff for providing effective cessation services is significant

Missouri's adult smoking prevalence has remained relatively constant over the past decade while in other states such as California, Massachusetts, and Oregon smoking declined significantly during the same period. In these states, intervention strategies were implemented such as increasing the state excise tax on tobacco products and using a portion of the proceeds to support a comprehensive tobacco use prevention program that included a well-funded cessation program component. Later, payments to states from the 1998 tobacco Master Settlement Agreement (MSA) were used to support comprehensive programs. The results have been remarkable as highlighted by the following:

- 33,000 fewer deaths occurred due to heart disease between 1989-1997 in California (CDC 2003).
- For every $1.00 spent on the California comprehensive program between 1990-1998, $3.62 was saved in direct medical costs (CDC 2003).
- Smoking during pregnancy declined from 25 percent in 1990 to 13 percent in 1996 in Massachusetts (CDC 2003).
- Oregon saved over $1 million in 2001 caring for low birth weight babies because of a 28 percent decline in smoking during pregnancy (Oregon 2003).
- 75,000 fewer adults and 25,000 fewer youth smoked in Oregon in 2003 compared to 1996 (Oregon 2003).

According to the Centers for Disease Control and Prevention (CDC 1999), a comprehensive tobacco control program includes the following components:

- **Community and school programs** to reduce tobacco use and exposure to secondhand smoke;
- **Cessation programs** to increase quitting;
- **Chronic disease programs** to reduce the burden of tobacco-related diseases;
- **Counter-marketing (media)** to educate and counter tobacco industry marketing;
- **Enforcement** to reduce youth access to tobacco products;
- **Surveillance and evaluation** to track changes in tobacco use and measure effectiveness of program activities; and
- **Administration and management** to ensure fiscal accountability and implementation of evidence-based strategies.



CDC estimated that the annual cost for Missouri to implement an effective comprehensive tobacco control program would range from $32.8 million to $91.4 million, including $6.3 to $29.9 million for cessation programs. Recommendations for how funding would be used to implement a comprehensive program in Missouri may be found in *Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009.*

Recommendations for Action: Cessation Program Component Plan

The Missouri State Cessation Workgroup recommended actions to further address four strategies to increase quitting among young people and adults outlined in *Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009.* Actions provide specific direction for how Missouri can implement a comprehensive, coordinated approach for effective cessation services to increase the number of smokers that successfully quit.

Because funding that is currently available for statewide cessation services is limited, the Cessation Workgroup established a targeted intervention for promoting cessation counseling and referrals to a state quitline, when established, to health care providers of low-income women with small children. The workgroup also established priorities for actions, which are designated with an asterisk (*) in the recommended actions that follow.

Strategy 1: *Increase the price of tobacco products*

Recommended Actions:

1. Advocate for increasing Missouri's excise tax on cigarettes and other tobacco products. At 17 cents per pack, Missouri's cigarette tax ranks fourth lowest among all states.
2. Ensure a portion of the tax proceeds is secured for implementing a comprehensive tobacco use prevention program in Missouri, including for a cessation program component, with the goal of attaining funding at the level recommended by CDC.

Strategy 2: *Promote quitting by adult and youth tobacco users*

Recommended Actions:

1. * Tailor messages for reaching the targeted intervention population to inform of available cessation services, including quitline counseling, and to create demand for services by utilizing the National Cancer Information Consumer Health Profiles data.
2. Create and utilize earned (free) media to create demand for cessation services by developing key messages regarding the importance of quitting, and assistance available for those wanting to quit. Identify champions/spokespersons in all areas of the state to deliver the messages to local media.

3. Implement a well-funded paid statewide media campaign to create demand for cessation services, including quitline counseling. Tailor messages for specific populations to counter tobacco industry marketing.
4. Develop and disseminate through existing networks and community coalitions materials tailored for use by employers and health systems to create demand for cessation services, including quitline counseling.
5. Require tobacco retailers to visibly display information about the state quitline.

Strategy 3: *Increase health care provider counseling for tobacco users*

Recommended Actions:

1. * Secure funding for provider reimbursement for cessation counseling, especially for Medicaid recipients, by working with state officials and health plans. Make the business case for cost-benefit of cessation counseling by health care providers in helping smokers to quit.
2. *Work with Primaris in revising a provider cessation toolkit to include quitline promotional information.
3. Explore legislation to require Medicaid and health plans to reimburse providers for cessation counseling.
4. Develop and conduct professional development for providers to increase knowledge and skills for counseling patients who smoke to quit by implementing recommendations of the *Clinical Practice Guideline: Treating Tobacco Use and Dependence*. Include in the training information about the effectiveness of pharmacotherapies in helping smokers to quit.
5. Disseminate cessation toolkits to providers for use in counseling patients that includes prompts to remind providers to use the 5A's (see glossary of terms) brief cessation counseling, recommended pharmacotherapy for patients, referral information for quitline or other counseling services, and suggestions for follow-up or after care to prevent relapse.
6. Convene medical and health care associations to discuss standardized protocol for clinic screening systems to assess patient tobacco use and counseling to quit.
7. Identify best practices among health care systems for cessation counseling and follow-up care to share with others through newsletters, list serves, and websites.
8. Explore innovative approaches such as reimbursing providers for brief counseling only if the patient quits, or reimburse based on quit rates of patients (e.g., incentives for reimbursement). Use cotinine tests to confirm patients' abstinence.

Strategy 4: *Increase available, affordable and accessible cessation services*

Recommended Actions:

1. *Secure funding to implement and evaluate effectiveness of a free proactive telephone counseling quitline that is available seven days a week with optimal hours of operation to ensure access. Secure funding by making the business case for the cost-benefit of quitline services.
2. *Work with health plans, employers, and state officials to secure funding for reducing smokers' out-of-pocket expense for cessation aids (especially for Medicaid recipients), including pharmacotherapy (prescription and over-the counter) and individual and group counseling. Make the business case for the cost-benefit of cessation aids in helping smokers to quit.

3. Explore legislation to require Medicaid and health plans to cover pharmacotherapies, including over-the-counter nicotine replacement therapy (NRT).
4. Maximize quitline referrals by health care providers by implementing a fax referral system. Seek funding for reimbursement for fax referrals by making the business case for cost-benefit of quitline services.
5. Implement measures to ensure access to and use of quitline services by providing private locations from which patients may make calls in medical practices, clinics, hospitals, and local public health agencies.
6. Integrate and link cessation services to increase access and use – brief cessation counseling by providers, referrals to quitline for free counseling, and access to free pharmacotherapies including over-the counter NRT. Require participation in proactive quitline counseling program to receive free NRT if not covered by a health plan.
7. Prompt actuarial analysis for smoking-related outcomes other than co-morbidity (e.g. cost of smoking-related auto accidents and house fires) to support the cost-benefit argument for cessation services.
8. Secure funding to implement surveillance and evaluation systems to measure the effectiveness of the cessation program component.

Appendix 1

Glossary of Cessation Terms

(Source: Fiore, et.al., 2000)

Clinic screening system. The strategies used in clinics and practices for delivery of clinical services involving changes in protocols designed to enhance the identification of and interventions with patients who smoke. Examples include affixing tobacco use status stickers to patients' charts, expanding the vital signs to include tobacco use, and incorporating tobacco-use status items in patient questionnaires.

Cessation Counseling:

Higher intensive counseling. Intervention that involves extended contact between clinicians and patients, coded based on length of contact greater than 10 minutes.

Low-intensity counseling. Intervention that involves contact between clinicians and patients that last between 3 and 10 minutes.

Minimal counseling (Brief provider counseling). Intervention that involves very brief contact (3 minutes or less) between clinicians and patients. The 5 A's brief intervention is recommended for use by clinicians (see Table 1).

Table 1: The "5 A's" for Brief Provider Intervention

ASK about tobacco use.	Identify and document tobacco use status for every patient at every visit.
ADVISE to quit.	In a clear, strong and personalized manner urge every tobacco user to quit.
ASSESS willingness to make a quit attempt.	Is the tobacco user willing to make a quit attempt at this time?
ASSIST in quit attempt.	For patient willing to make a quit attempt, use counseling and pharmacotherapy to help.
ARRANGE follow-up	Schedule follow-up contact, preferably within first week after quit date.

Pharmacotherapy. Medication used to treat tobacco dependence.

- Medications found to be safe and effective for tobacco dependence treatment, and have been approved by the Food and Drug Administration (FDA) for use as smoking cessation interventions.
  - **Buproprion SR (buproprion sustained-release).** A non-nicotine prescription aid to smoking cessation originally developed and marketed as an antidepressant.
  - **Nicotine replacement therapy (NRT).** Over-the-counter medication containing nicotine that is intended to promote smoking cessation. Four NRT delivery systems currently approved by the FDA for use in the United States are nicotine gum, inhaler, patch and nasal spray.

Serum cotinine. Level of cotinine in the blood used to estimate a patient's tobacco/nicotine use prior to quitting, and to confirm abstinence self-reporting during follow-up. Cotinine is typically measured in urine and saliva, and has a longer half-life than nicotine.

Targeted intervention. Intervention that focuses on a particular population (e.g., pregnant women).

Telephone hotline/helpline (Reactive telephone counseling). Telephone cessation counseling initiated by a patient who calls a clinician.

Telephone cessation quitline (Proactive telephone counseling). Telephone cessation counseling initiated by a clinician who calls a patient.

Appendix 2

References

Burns DM. Smoking cessation: recent indicators of what's working at a population level. *Smoking and Tobacco Control Monograph No. 12*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 00-4892; November 2000:99-128. In: CDC. *Telephone Quitlines.* 2004

Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. August 1999.

CDC. Cigarette smoking among adults-United States, 2000. *Morbidity and Mortality Weekly Report* 2002; 51(29): 642-645.

CDC. *Preventing Chronic Diseases: Investing Wisely in Health - Preventing Tobacco Use.* Atlanta, GA: Office on Smoking and Health, 2003.

CDC. *Telephone Quitlines: A Resource for Development, Implementation, and Evaluation*. Atlanta, GA: Office on Smoking and Health, 2004.

CDC. Smoking During Pregnancy — United States, 1990-2002. *Morbidity and Mortality Weekly Report 2004;* 53(39): 911-915.

CDC. State Estimates of Neonatal Health-Care Costs Associated with Maternal Smoking-United States, 1996. *Morbidity and Mortality Weekly Report* 2004; 53(39): 915-917.

Fiore MC, Bailey WC, Cohen SJ, et.al., *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

Hopkins DP, Fielding JE, et.al., Task Force on Community Preventive Services. Recommendations Regarding Interventions to Reduce Tobacco Use and Exposure to Environmental Tobacco Smoke and Reviews of Evidence Regarding Interventions to Reduce Tobacco Use and Exposure to Environmental Tobacco Smoke. *American Journal of Preventive Medicine* 20(2S): 10-52. February 2001.

Pacific Center on Health and Tobacco. *Linking a Network: Integrate Quitlines with Health Care Systems*. Portland, OR: Pacific Center on Health and Tobacco. July 2003.

Oregon Department of Human Services and Health. *Making Oregon Healthier: Saving Lives and Saving Dollars*. Salem: OR. 2003.

Oregon, Tobacco-free Coalition of. *Making the Quitting Connection Evaluation Summary, Report to the Oregon Health Plan, December 2002.* In: Pacific Center on Health and Tobacco. *Linking A Network: Integrate Quitlines with Health Care Systems.*

Stead LF, Lancaster T, Perera R. Telephone counseling for smoking cessation. *The Cochrane Library 2004,* Issue 1. Chichester, UK: John Wiley & Sons, Ltd. In: CDC. Telephone Quitlines. 2004.

Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003—2009

Recommendations for Action: Cessation Program Component

May 2005

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
dhss